Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

DABASIS DASGUPTA, MD
PO BOX 741865
DALLAS, TX 75374

Respondent Name
NEW HAMPSHIRE INSURANCE CO

Carrier's Austin Representative Box
Box Number 19

MFDR Tracking Number
M4-11-4624-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "CARRIER IS REQUIRED TO PAY DD EXAMS"

Amount in Dispute: $500.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: A copy of dispute was placed in carrier rep box on August 11, 2011 with no response to MFDR.

Response Submitted by: NA

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
February 24, 2011	99456-RE-W6	$500.00	$500.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §134.204 sets out Medical Fee Guidelines for workers' compensation specific services effective March 1, 2008.
3. Texas Labor Code Title 5, Subtitle A, Chapter Subchapter A, in §408.0041(a-h) provides general provisions for Designated Doctor (DD) Examinations and carrier responsibilities for payment of such services.

4. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated May 03, 2011
   - 218 –Based on entitlement to benefits

Issues

1. Has the Designated Doctor (DD) Examination been reimbursed appropriately per 28 Texas Administrative Code §134.204?
2. Is the requestor entitled to reimbursement?

Findings

1. The provider (DD) billed the amount of $500.00 for CPT code 99456-RE-W6 for an extent of injury (EXT) determination. Documentation supports that the requestor performed the Division ordered services as requested on the DWC-32.

   Respondent denied services based on "218 –Based on entitlement to benefits".

   Texas Labor Code §408.0041 states in part (a)(3)
   (a) At the request of an insurance carrier or an employee, or on the commissioner's own order, the commissioner may order a medical examination to resolve any question about:
   (3) the extent of the employee's compensable injury;

   Texas Labor Code §408.0041 states in (h)(1):
   (h) The insurance carrier shall pay for:
   (1) an examination required under Subsection (a) or (f).

2. The requestor performed the exam ordered by the Division, and is therefore entitled to reimbursement. Per 28 Texas Administrative Code §134.204(i)(2)(A) & (k), the Maximum Allowable Reimbursement (MAR) for a return to work (RTW) examination and/or evaluation of medical care (EMC) is $500.00.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that reimbursement is due. As a result, the amount ordered is $500.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $500.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature	Gregory Fournerat Medical Fee Dispute Resolution Officer	November 4, 2011 Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party.**

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.